

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3266

CERTIFICATE OF DEATH

Reg. Dist. No.

03257

| | | | | | | | |
|--|----------------------------------|---|---|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY St Mary's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY St Mary's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Drayden | | | | c. LENGTH OF STAY IN lb Life | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) First Edward Middle Adams Last Adams | | | | 4. DATE OF DEATH Month March Day 7 Year 1956 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 10, 1876 | | 9. AGE (In years last birthday) 79 yrs. | IF UNDER 1 YEAR Months 5 Days 25 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George Adams | | | | 14. MOTHER'S MAIDEN NAME Julia Adams | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Helen Mae Adams Address Drayden, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Viral pneumonia 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cervical cancer | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from March 4, 1956 , to March 7, 1956 , that I last saw the deceased alive on March 6, 1956 , and that death occurred at 1 A M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE P.J. Bean M.D. | | | | ADDRESS (Street, city or town, state) Great Mills, Md. DATE SIGNED 3/7/56 | | | |
| PHYSICIAN'S NAME (Type) P.J. Bean M.D. | | | | Great Mills, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/9/56 | | 22c. NAME OF CEMETERY OR CREMATORY St George's | | 22d. LOCATION (City, town, or county) (State) Valley Lee, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Mattingley | | | | ADDRESS Leonardtwn, Md. | | 24a. REC'D BY REGISTRAR DATE 3/7/56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE P. J. Bean | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. J.

MAR 12 1956

RECEIVED
BUREAU V. J.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3267

CERTIFICATE OF DEATH

03238

Reg. Dist. No. 252

| | | | | | | | |
|--|------------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Drayden | | | | c. LENGTH OF STAY IN 1b Life | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00 | | | | d. STREET ADDRESS Drayden | | | |
| 3. NAME OF DECEASED (Type or print) Robert Alexander Armstrong | | | | 4. DATE OF DEATH Month March Day 11 Year 19 56 | | | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH October 6 1868 | 9. AGE (In years (last birthday) yrs. 87 | IF UNDER 1 YEAR IF UNDER 24 HRS. Months 5 Days 11 Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Alexander Armstrong | | | | 14. MOTHER'S MAIDEN NAME Caroline Armstrong | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Mrs. Florence Shade Drayden Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arterio sclerosis DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2-3 weeks | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) malnutrition | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from on 3-10-1956 , to 1956 , that I last saw the deceased alive on 3-10-1956 , and that death occurred at 7:30 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE James J. Kelly M.D. | | | | ADDRESS (Street, city or town, state) Drayden Md. DATE SIGNED 3-12-56 | | | |
| PHYSICIAN'S NAME (Type) James J. Kelly, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/14/1956 | | 22c. NAME OF CEMETERY OR CREMATORY St. George's | | 22d. LOCATION (City, town, county) (State) Valley Lee, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Mattingly | | | | ADDRESS Leonardtwn Md. | | 24a. REC'D BY REGISTRAR DATE 3/12/56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE James J. Houser | | | |

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE 10

1956

DATE

TIME

PLACE

CAUSE

++

BUREAU V. S.

MAR 13 1956

RECEIVED

OFFICE OF THE ATTORNEY GENERAL

OFFICE OF THE ATTORNEY GENERAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G19, 3-21-56

3268

CERTIFICATE OF DEATH

03239

Reg. Dist. No. 282

| | | | | | | | |
|---|------------------------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD Mechanicsville | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS Rural | | | |
| 3. NAME OF DECEASED (Type or print) Johanna C. Bankins | | | | 4. DATE OF DEATH Month March Day 13 Year 19 56 | | | |
| 5. SEX female | 6. COLOR OR RACE colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 7, 1908 | | 9. AGE (In years last birthday) 47 48 yrs. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Domestic | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John M. Young | | | | 14. MOTHER'S MAIDEN NAME Mary E. Price | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT Louis D. Young - Loveville, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of cervix with metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ----- DUE TO (c) ----- | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 year | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ----- | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 1, 1955 to Mar 13, 1956 , that I last saw the deceased alive on Mar 1, 1956 , and that death occurred at 3:47 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE J. Roy Guither M.D. | | | | ADDRESS (Street, city or town, state) Mechanicsville, Md. DATE SIGNED 3/13/56 | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/15/56 | | 22c. NAME OF CEMETERY OR CREMATORY St. Joseph Cemetery | | 22d. LOCATION (City, town, or county) (State) Morganza, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson | | | | ADDRESS Leonardtwn, Md. | | 24a. REC'D BY REGISTRAR DATE 3/15/56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Glenn Houser | | | |

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

| | | | |
|---|--|---|--|
| <p>1. Name of Deceased: <i>John A. Smith</i></p> | | <p>2. Date of Death: <i>March 15, 1956</i></p> | |
| <p>3. Place of Birth: <i>Boston, Mass.</i></p> | | <p>4. Age at Death: <i>45</i></p> | |
| <p>5. Sex: <i>Male</i></p> | | <p>6. Race: <i>White</i></p> | |
| <p>7. Occupation: <i>Engineer</i></p> | | <p>8. Cause of Death: <i>Heart Disease</i></p> | |
| <p>9. Date of Burial: <i>March 17, 1956</i></p> | | <p>10. Place of Burial: <i>St. John's Church</i></p> | |
| <p>11. Signature of Physician: <i>[Signature]</i></p> | | <p>12. Signature of Registrar: <i>[Signature]</i></p> | |

BUREAU V. 2

MAR 16 1956

RECEIVED

3269

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY St Mary's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St Mary's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Leonardtown | | | | c. LENGTH OF STAY IN 1b 1 day | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St Mary's Hoospital | | | | d. STREET ADDRESS Rural XXXXX Abell X | | | |
| 3. NAME OF DECEASED (Type or print) First Sadie Middle F. Last Butler | | | | 4. DATE OF DEATH Month March Day 21 Year 19 56 | | | |
| 5. SEX Female | | 6. COLOR OR RACE Colored | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH August 15, 1876 | |
| 9. AGE (In years last birthday) 79 yrs. | | IF UNDER 1 YEAR Months 7 Days 6 Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| | | | | 11. BIRTHPLACE (State or foreign country) Maryland | | | |
| 13. FATHER'S NAME George Fillmore | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | | | 16. SOCIAL SECURITY NO. None | | | |
| 17. INFORMANT Miss Carrie J. Jamerson | | | | Address Abell, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Failure DUE TO (c) Chronic Myocarditis | | | | | | INTERVAL BETWEEN ONSET AND DEATH 42 hours Several weeks Several years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from April 23, 1944 , to March 21, 1956 , that I last saw the deceased alive on March 21, 1956 , and that death occurred at 4:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Leonardtown, Md. DATE SIGNED 3/22/56 | | | | | | | |
| ACTUAL SIGNATURE Robert F. Fuchs | | | | M.D. Leonardtown, Md. | | | |
| PHYSICIAN'S NAME (Type) Robert Fuchs M.D. | | | | Leonardtown, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/24/56 | | 22c. NAME OF CEMETERY OR CREMATORY All Saints | | 22d. LOCATION (City, town, or county) (State) Oakley, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Mattingly | | | | ADDRESS Leonardtown, Md. | | 24a. REC'D BY REGISTRAR DATE 3/22/56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Charles J. Mattingly | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital and the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|--|--|---|--|
| <p>1. Name of deceased: <u>JOHN J. BROWN</u></p> | | <p>2. Sex: <u>Male</u></p> | |
| <p>3. Date of birth: <u>1901</u></p> | | <p>4. Place of birth: <u>MASSACHUSETTS</u></p> | |
| <p>5. Date of death: <u>1956</u></p> | | <p>6. Place of death: <u>BOSTON</u></p> | |
| <p>7. Cause of death: <u>Heart Disease</u></p> | | <p>8. Manner of death: <u>Natural</u></p> | |
| <p>9. Signature of physician: <u>[Signature]</u></p> | | <p>10. Signature of registrar: <u>[Signature]</u></p> | |
| <p>11. Date of registration: <u>1956</u></p> | | <p>12. Place of registration: <u>BOSTON</u></p> | |

BUREAU A. 1

MAR 27 1956

RECEIVED

3270

CERTIFICATE OF DEATH

Reg. Dist. No. 03242

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>ST. MARKS</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LEONARDTOWN</u> | | c. LENGTH OF STAY IN 1b <u>5 mo.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MD</u> | | e. STREET ADDRESS <u>WILLIAMS ST.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>SALLY</u> Middle <u>GAULT</u> Last <u>CROPPER</u> | | 4. DATE OF DEATH Month <u>MAR.</u> Day <u>2</u> Year <u>1956</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MAR. 5, 1869</u> |
| 9. AGE (In years last birthday) <u>96</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>INDIANA.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>ARCHIBALD GAULT</u> | | 14. MOTHER'S MAIDEN NAME <u>MARY ANNE TILGHMAN.</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>No</u> | |
| 17. INFORMANT Address <u>MRS. VERA RICHARDSON, LEONARDTOWN, MD.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hour</u> <u>3 yrs.</u> |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>12 Feb.</u> , 19 <u>56</u> , to <u>2 Mar.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2 Mar.</u> , 19 <u>56</u> , and that death occurred at <u>8:30 A.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Joseph E. Gill</u> M.D. | | ADDRESS (Street, City or town, State) <u>Leonardtown, Md.</u> DATE SIGNED <u>3 Mar 56</u> | |
| PHYSICIAN'S NAME (Type) <u>JOSEPH E. Gill</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>3/5/56</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>BOWEN</u> | 22d. LOCATION (City, town, or county) (State) <u>NEWARK MD</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u> ADDRESS <u>Berlin Md</u> | | 24a. REC'D BY REGISTRAR <u>MAR 6 1956</u> 24b. REGISTRAR'S SIGNATURE <u>W. D. Dausen</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WEST LAND STATE DEPARTMENT OF HEALTH - ALBANY

BUREAU V. S.

MAR 7 1950

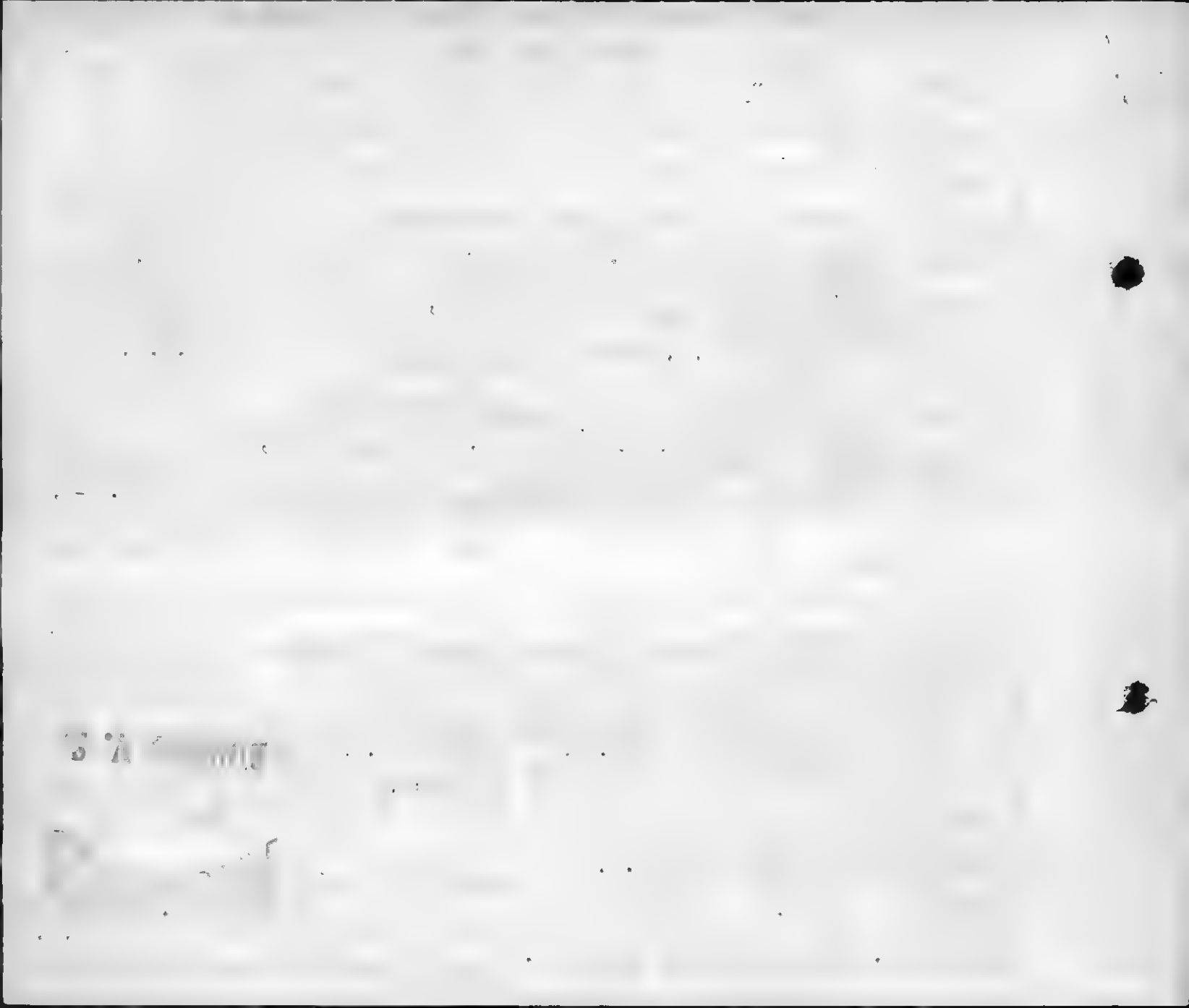
RECEIVED

3271
CERTIFICATE OF DEATH

Reg. Dist. No. 282

| | | | | | | | |
|--|----------------------------------|---|---|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY St Mary's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY St Mary's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Compton | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) Alma G. Cryer | | | | 4. DATE OF DEATH Month March Day 10 Year 1956 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 17, 1886 | | 9. AGE (In years last birthday) 69 yrs | IF UNDER 1 YEAR: Months 11 Days 22 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Government | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 578 28 7462 | | 17. INFORMANT James W. Cryer Address Compton, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 381X DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH Feb. 27-3, 5 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb. 27, 1956 , to Mar. 5, 1956 , that I last saw the deceased alive on March 5, 1956 , and that death occurred at 10:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Leonardtown, Maryland DATE SIGNED Charles Greenwell | | | | | | | |
| ACTUAL SIGNATURE Charles Greenwell M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) Charles Greenwell M.D. Leonardtown, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/13.56 | | 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | 22d. LOCATION (City, town, or county) (State) 4000 Suitland Rd. Washington | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Mattingly | | | | ADDRESS Leonardtown, Md. | | 24a. REC'D BY REGISTRAR DATE 3/12/56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE D.C. | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

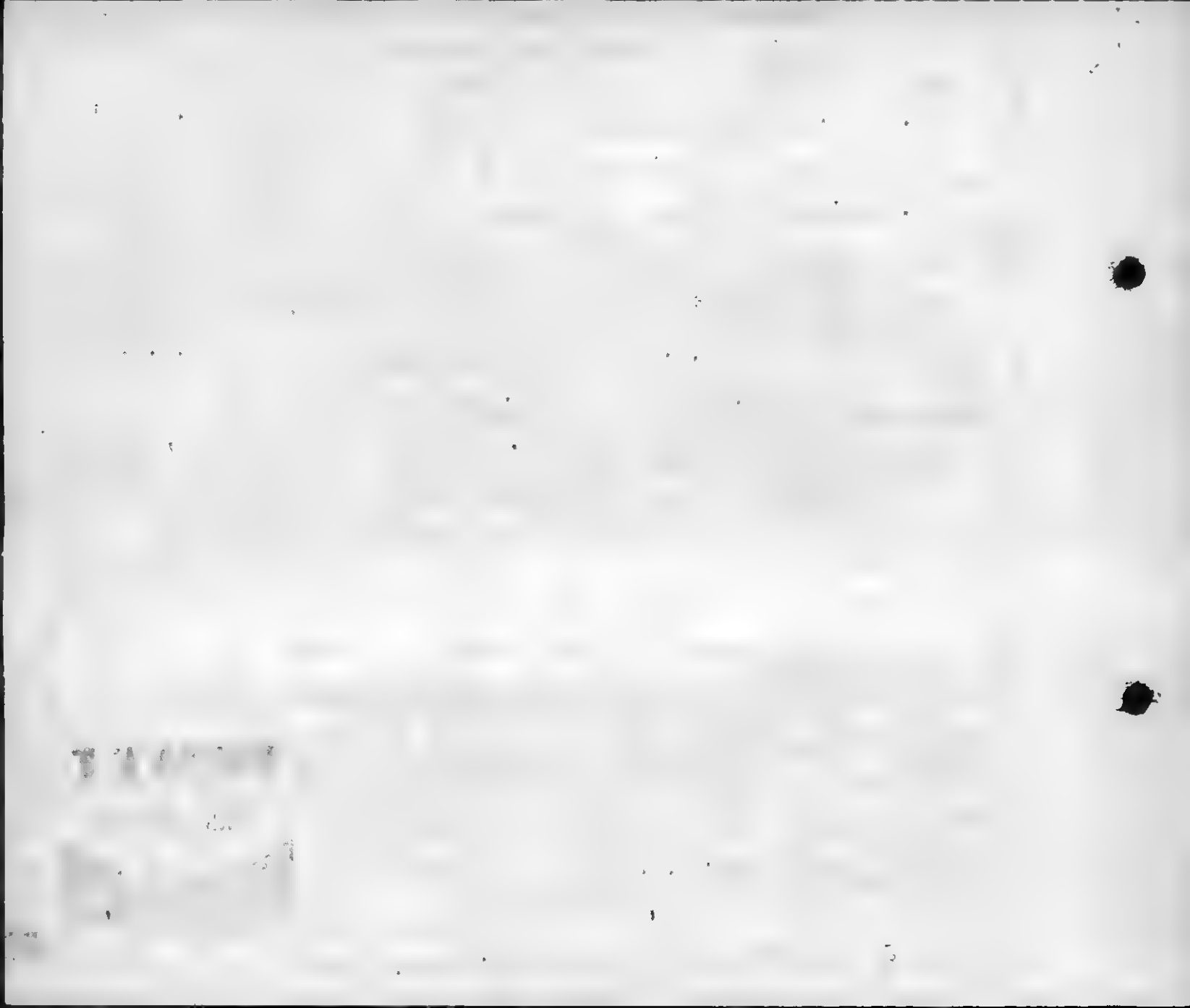
Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY St. Mary's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtowntown | | | | c. LENGTH OF STAY IN 1b 84 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle Edith Last Drury | | | 4. DATE OF DEATH Month March Day 11 Year 19 56 | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH January 22 1907 | | 9. AGE (In years last birthday) 59 yrs. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Government | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Neal W. Davis | | | | 14. MOTHER'S MAIDEN NAME P. Ann Howard | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT E. Howard Davis | | Address Compton, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic CV disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 60 days 10 yrs |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) White of work <input type="checkbox"/> Not white of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 19 49 to Mar 11 1956 , that I last saw the deceased alive on Mar 9 1956 , and that death occurred at Md. from the causes and on the date stated above. ADDRESS (Street, city or town) Mechanicsville, Md. DATE SIGNED 3/11/56 | | | | | | | |
| ACTUAL SIGNATURE Roy Guyther M.D. | | | | PHYSICIAN'S NAME (Type) Roy Guyther M.D. Mechanicsville, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/14/56 | | 22c. NAME OF CEMETERY OR CREMATORY St. Francis Xavier | | 22d. LOCATION (City, town, or county) (State) Compton Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles J Mattingly | | | | ADDRESS Leonardtowntown Md. | | 24a. REC'D BY REGISTRAR DATE 3/13/56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Heidi M. Adams | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

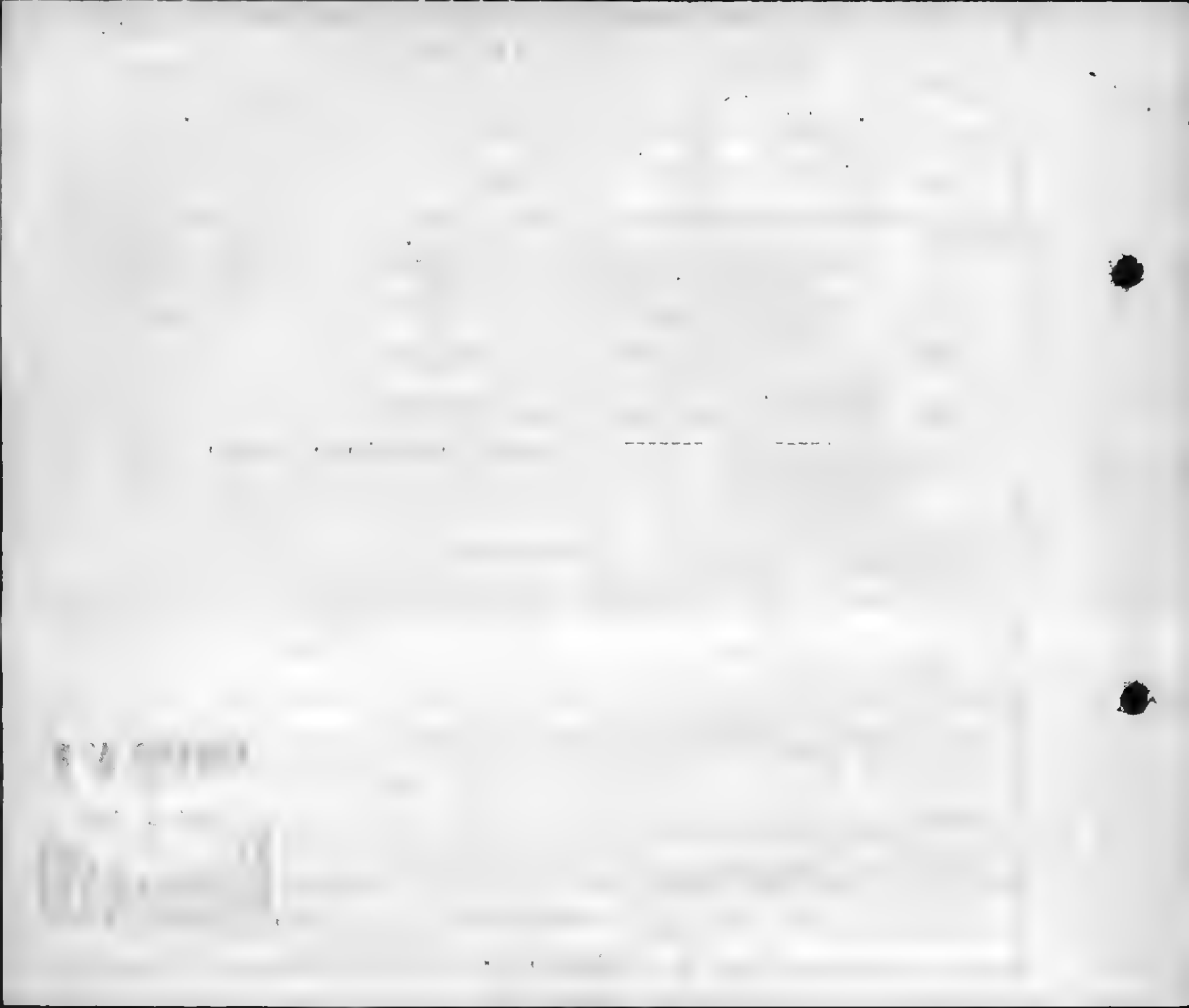
282

3273

| | | | | | | | |
|--|----------------------------------|---|--|--|--|---|------------------------------|
| 1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution—Residence before admission) a. STATE Maryland b. COUNTY St. Marys | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abell | | c. LENGTH OF STAY IN 1b life | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abell | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural | | | | d. STREET ADDRESS Rural | | | |
| 3. NAME OF DECEASED (Type or print) First Joseph Middle Evans Last Sr. Faunce | | | | 4. DATE OF DEATH Month March Day 30 Year 1956 | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1 / 24 / 1883 | | 9. AGE (In years last birthday) 73 yrs | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman | | 10b. KIND OF BUSINESS OR INDUSTRY Sea Food | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Jake Faunce | | | | 14. MOTHER'S MAIDEN NAME Emma Selby | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT Joseph E. Faunce, Jr. - Abell, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac failure 460A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal failure DUE TO (c) Renal vein thrombosis | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1/2 hour 10 days 12 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from 15 March, 1956 , to 30 March, 1956 , that I last saw the deceased alive on 20 March, 1956 , and that death occurred at 11:00 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Joseph E. Gill | | | | ADDRESS (Street, city or town, state) Leonardtown, Md | | | |
| PHYSICIAN'S NAME (Type) JOSEPH E. GILL | | | | DATE SIGNED 3/30/56 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4/2/56 | | 22c. NAME OF CEMETERY OR CREMATORY All Saints Cemetery | | 22d. LOCATION (City, town, or county) (State) Oakley, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robinson | | | | ADDRESS - Leonardtown, Md. | | 24a. REC'D BY REGISTRAR DATE 4/2/56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE William M. Harris | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MD STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

item 14, Film 93 3-4-56 et

CERTIFICATE OF DEATH

03246
281

Reg. Dist. No.

3274

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY St Mary's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution, residence before admission) a. STATE Maryland b. COUNTY St Mary's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hollywood | | | | c. LENGTH OF STAY IN 1b 60 yrs | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hollywood | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) Lucy Virginia Gatton | | | | 4. DATE OF DEATH Month March Day 1 Year 19 56 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Jan. 19, 1876 | |
| 9. AGE (In years last birthday) 80 yrs | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME Algier Elliott | | | |
| 14. MOTHER'S MAIDEN NAME Unknown | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. None | | | | 17. INFORMANT Marshall Gatton Address Hollywood, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arterio sclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arterio sclerosis DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 years 15 years | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from May 1, 1946 to March 1, 1956 , that I last saw the deceased alive on Feb 23, 1956 , and that death occurred at 11:45 PM from the causes and on the date stated above. ACTUAL SIGNATURE P. J. Bean M.D. ADDRESS (Street, city or town, state) Great Mills, Md. DATE SIGNED 3/3/56 PHYSICIAN'S NAME (Type) P. J. Bean M.D. Great Mills, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/4/56 | | 22c. NAME OF CEMETERY OR CREMATORY Nazarene | | 22d. LOCATION (City, town, or county) (State) Hollywood, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Mattingly | | | | ADDRESS Leonardtwn, Md. | | 24a. REC'D BY REGISTRAR DATE 3/3/56 | |
| 24b. REGISTRAR'S SIGNATURE P. J. Bean | | | | 24c. REGISTRAR'S SIGNATURE P. J. Bean | | | |

U.S. AIR FORCE

MAR 6 1956

OFFICIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3275 CERTIFICATE OF DEATH

03247

Reg. Dist. No. 287

| | | | | | | | |
|--|---------------------------------|---|---|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridge | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridge | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural | | | | d. STREET ADDRESS Rural | | | |
| 3. NAME OF DECEASED (Type or print) First Joseph Middle Franklin Last Gough | | | | 4. DATE OF DEATH Month March Day 16 Year 1956 | | | |
| 5. SEX male | 6. COLOR OR RACE colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10 June 1923 | | 9. AGE (In years last birthday) 32 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor | | 10b. KIND OF BUSINESS OR INDUSTRY Sea Food | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William G. Gough | | | | 14. MOTHER'S MAIDEN NAME Julia Hewlett | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 218-16-3289 | | 17. INFORMANT Robert M. Gough - Scotland, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Heart failure DUE TO (c) Heart failure | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour 0. 11 p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from March 14, 1956 , to March 16, 1956 , that I last saw the deceased alive on March 14, 1956 , and that death occurred at 8: P. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE P. J. Bean M.D. | | | | ADDRESS (Street, city or town, state) Quantico, Md. | | | |
| PHYSICIAN'S NAME (Type) P. J. BEAN MD | | | | DATE SIGNED 3/17/56 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/19/56 | | 22c. NAME OF CEMETERY OR CREMATORY St. Lukes Cemetery | | 22d. LOCATION (City, town, or county) (State) Scotland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robinson | | | | ADDRESS - Leonardtown, Md. | | 24a. REC'D BY REGISTRAR DATE 3/17/56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Frank Robinson | | | |

RECEIVED

3276

CERTIFICATE OF DEATH

Reg. Dist. No. 282

| | | | | | | | |
|---|----------------------------------|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY St Mary's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY St Mary's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn | | | | c. LENGTH OF STAY IN 1b Life | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) First James Middle Combs Last Greenwell SR. | | | | 4. DATE OF DEATH Month March Day 4 Year 1956 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 10, 1892 | | 9. AGE (In years last birthday) 63 yrs | IF UNDER 1 YEAR Months 11 Days 23 Hours Min | IF UNDER 24 HRS. Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming | | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME James J. Greenwell | | | | 14. MOTHER'S MAIDEN NAME Mary Rosa Combs | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. 217-14-7842 | | 17. INFORMANT James C. Greenwell Jr. Leonardtown, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Super-renal Gland 195X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer spread to intestinal organs DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 months |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Aug. 12, 1956 to March 4 , 19 56 , that I last saw the deceased alive on March 4 , 19 56 , and that death occurred at 3:00 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Leonardtwn Md DATE SIGNED March 15 56 | | | | | | | |
| ACTUAL SIGNATURE Charles Greenwell M.D. | | | | DATE SIGNED March 15 56 | | | |
| PHYSICIAN'S NAME (Type) Charles X. Greenwell M.D. | | | | Leonardtwn, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/6/56 | | 22c. NAME OF CEMETERY OR CREMATORY St Aloysius | | 22d. LOCATION (City, town, or county) (State) Leonardtwn, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Mattingly | | | | ADDRESS Leonardtwn, Md. | | 24a. REC'D BY REGISTRAR DATE 3/7/56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE John A. Sawyer | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TEAU V. 9

MAR 2

150

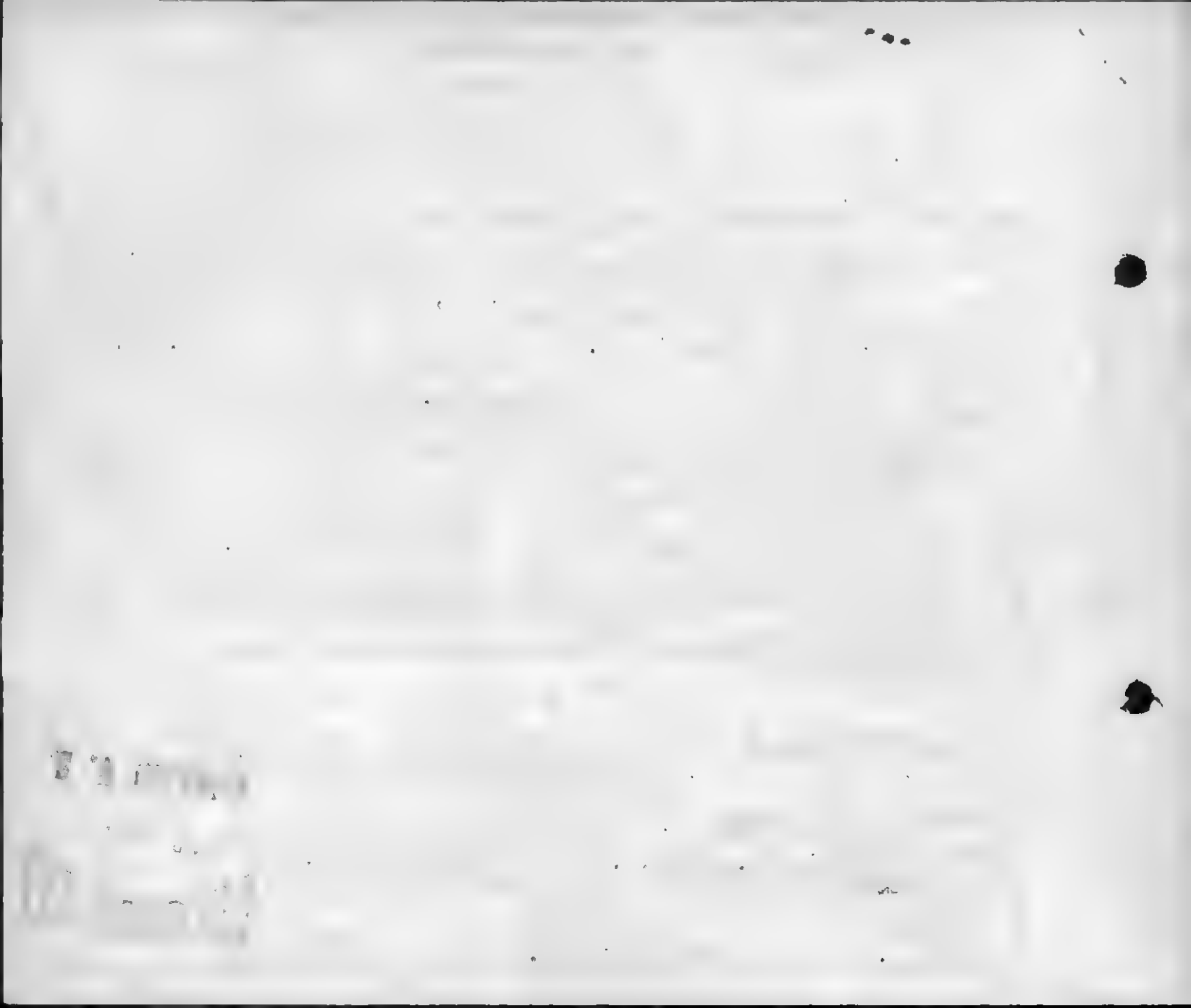
3277

CERTIFICATE OF DEATH

Reg. Dist. No. 282

| | | | | | | | |
|---|----------------------------------|---|---|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY St Mary's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY St Mary's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn | | | | c. LENGTH OF STAY IN 1b XXXX | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St Mary's Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Lancaster Eugene Hall | | | | 4. DATE OF DEATH Month March Day 25 Year 19 56 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 30, 1898 | | 9. AGE (In years last birthday) 58 yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS Months 1 Days 24 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Driver | | | 10b. KIND OF BUSINESS OR INDUSTRY Transit Co. | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Eugene Hall | | | | 14. MOTHER'S MAIDEN NAME Alice E. Tennyson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give branch or dates of service) No | | 16. SOCIAL SECURITY NO. 151-03-0843 | | 17. INFORMANT Address Mrs Dorothy Hall Leonardtown, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis heart disease DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 30 min 3 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | |
| | | | 20f. (City or town) | | (County) (State) | | |
| 21. I certify that I attended the deceased from 3/28 , 19 52 , to 3/25 , 19 56 , that I last saw the deceased alive on 3/25 , 19 56 , and that death occurred at 5:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Leonardtwn, Maryland DATE SIGNED 3/26/56 | | | | | | | |
| ACTUAL SIGNATURE Wm D Boyd M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) William D. Boyd M.D. Leonardtwn, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/28/56 | | 22c. NAME OF CEMETERY OR CREMATORY St Aloysius | | 22d. LOCATION (City, town, or county) (State) Leonardtwn, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Mattingly | | | | ADDRESS Leonardtwn, Md. | | 24a. REC'D BY REGISTRAR DATE 3/27/56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Wm J. H. H. | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03250

3278

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

282

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY St Mary's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY St Mary's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Budds Creek | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Budds Creek | | | |
| c. LENGTH OF STAY IN lb Life | | | | d. STREET ADDRESS | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Edward Middle Rencher Last Rencher | | | | 4. DATE OF DEATH Month March Day 23 Year 1956 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1895 | |
| 9. AGE (In years last birthday) 60 yrs. | | IF UNDER 1 YEAR Months 60 Days 0 Hours 0 Min. | | IF UNDER 24 HRS. Hours 0 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming | | | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME John Rencher | | | | 14. MOTHER'S MAIDEN NAME Rebecca Davis | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Henry Rencher Leonardtown, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause, per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fire from shot gun wound of liver DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) shot self | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour 3:23 a. m. 19 p. m. 56 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | | | | 20f. (City or town) Budds Creek (County) St. Mary's (State) Md. | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Julian S. Lane M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Julian S. Lane M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 3/29/56 | | 22c. NAME OF CEMETERY OR CREMATORY St. Joseph's | |
| | | | | 22d. LOCATION (City, town, or county) St. Joseph | | (State) Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Mattingly | | | | ADDRESS Leonardtown, Md. | | 24a. REC'D BY REGISTRAR 3/29/56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Heard H. Howells | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

U. S. A.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3279

CERTIFICATE OF DEATH

Reg. Dist. No.

03251

| | | | | | | | |
|--|--|---|--|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY St Mary's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St Mary's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown | | | | c. LENGTH OF STAY IN 1b 1 day | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 78 St Mary's Hospital | | | | d. STREET ADDRESS Palmers | | | |
| 3. NAME OF DECEASED (Type or print) First Selma Middle Teresa Last Renschke | | | | 4. DATE OF DEATH Month March Day 26 Year 1956 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Nov. 20, 1866 | |
| 9. AGE (In years last birthday) 89 yrs. | | IF UNDER 1 YEAR Months 4 Days 6 Hours Min. | | IF UNDER 24 HRS Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Germany | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Frank Hesse | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. None | | | |
| 17. INFORMANT Miss Gertrude Renschke Palmers, Md. | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 221x DUE TO infection Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) infection DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 24 hrs 2 years |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from March 26, 1956 to March 26, 1956 , that I last saw the deceased alive on March 26, 1956 , and that death occurred at 10:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Leonardtown, Md. DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE William D. Boyd M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) WILLIAM D. BOYD M.D. Leonardtown, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/28/56 | | 22c. NAME OF CEMETERY OR CREMATORY Sacred Heart | | 22d. LOCATION (City, town, or county) (State) Bushwood, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Mattingly | | | | ADDRESS Leonardtown, Md. | | 24a. REC'D BY REGISTRAR DATE 3/28/56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The certificate has been signed by the attending physician and completed in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5 A 1

000

74

00

3280

CERTIFICATE OF DEATH

Reg. Dist. No. 282

| | | | | | | | |
|---|------------------------------------|--|---|--|--|--|------------------|
| 1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD - Mechanicsville | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD - Mechanicsville | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS Rural | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Dorthy Marie Scriber | | | | 4. DATE OF DEATH Month Day Year March 15 1956 | | | |
| 5. SEX female | 6. COLOR OR RACE colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 26, 1954 | | 9. AGE (In years last birthday) 1 yrs. | IF UNDER 1 YEAR Months Days Hours Min 10 | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY none | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Francis E. Scriber | | | | 14. MOTHER'S MAIDEN NAME Mary H. Bankins | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT Address Francis E. Scriber- RFD Mechanicsville, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, broncho- 4-11X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3d. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Mar 13, 1956 , to Mar 13, 1956 , that I last saw the deceased alive on Mar 13, 1956 , and that death occurred at 5:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mechanicsville DATE SIGNED 3/15/56 ACTUAL SIGNATURE J. Roy Gupker M.D. PHYSICIAN'S NAME (Type) J. Roy Gupker | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/18/56 | | 22c. NAME OF CEMETERY OR CREMATORY St. Joseph Cemetery | | 22d. LOCATION (City, town, or county) (State) Morganza, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE P. B. Robinson | | | | ADDRESS - Leonardtown, Md. | | 24a. REC'D BY REGISTRAR DATE 3/19/56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE W. H. Hanner | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3281

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ST. MARY'S | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park | | | | c. LENGTH OF STAY IN lb 1yr and 1/2 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 531 Saratoga Drive | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First THOMAS Middle J Last TIGHE | | | | 4. DATE OF DEATH Month MARCH Day 29 Year 19 56 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 10, 1904 | | 9. AGE (In years last birthday) 51 yrs | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Service Employee | | 10b. KIND OF BUSINESS OR INDUSTRY U S Naval Air Station | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Thomas J. Tighe | | | | 14. MOTHER'S MAIDEN NAME Virginia Marstelle | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II | | 16. SOCIAL SECURITY NO. 218-28-4626 | | 17. INFORMANT Mrs. Evelyn E. Tighe- Wife - Same as # 2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4-2-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO (c) hypertension | | | | | | INTERVAL BETWEEN ONSET AND DEATH 15 min | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. none 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 27 1956 , to March 31 1956 , that I last saw the deceased alive on March 31 1956 , and that death occurred at 2:54 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lexington Park, Md. DATE SIGNED April 1 1956 | | | | | | | |
| ACTUAL SIGNATURE William S. Lane M.D. Lexington Park, Md. | | | | | | | |
| PHYSICIAN'S NAME (Type) William S. Lane Lexington Park, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF March 31, 56 | | 22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery | | 22d. LOCATION (City, town, or county) (State) Annapolis, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME | | | | ADDRESS ANNAPOLIS, MARYLAND | | 24a. REC'D BY REGISTRAR DATE 3 29 56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Mr. A. B. Dumas | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate must be filed in by the registrar of death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete certificate must be filed in by the registrar of death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 1 1967

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03255

3282 CERTIFICATE OF DEATH

Reg. Dist. No. 281

| | | | | | | | |
|--|--------------------------------------|--|--|--|---|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>St. Marys</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>St. Marys</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lexington Park</u> | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lexington Park</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Station Hospital, U.S. Naval Air Station, Patuxent River, Maryland</u> | | | | STREET ADDRESS (If rural give location) <u>101 Chinlee Drive</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) <u>Donna Marie Weed</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>March 12 19 56</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Caucasian</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u> | 8. DATE OF BIRTH <u>25 January 1956</u> | 9. AGE last birthday ----- yrs. | IF UNDER 1 YEAR Months Days <u>47</u> | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ----- | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Ernest Edmund Weed Jr.</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Lillian Arlene Mercurio</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT'S ADDRESS <u>Ernest Edmund Weed Jr. 101 Chinlee Drive, Lexington Park, Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 492X IMMEDIATE CAUSE (A) <u>Pneumonitis</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION ----- | | 19b. MAJOR FINDINGS OF OPERATION ----- | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. INJURY OCCURRED | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>12 March</u>, 19 <u>56</u>, to <u>12 March</u>, 19 <u>56</u>, that I last saw the deceased alive on <u>12 March</u>, 19 <u>56</u>, and that death occurred at <u>07:10AM</u>, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>J. H. Harris</u> | | | | ADDRESS (Street, city, town, state) <u>U.S. HARRIS LT MC USNR M.D. Station Hospital, USNAS, Patuxent River, Md.</u> | | DATE SIGNED | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Transportation</u> | | DATE THEREOF <u>3/14/56</u> | | NAME OF CEMETERY OR CREMATORY <u>Quincy, Massachusetts</u> | | LOCATION (City, town, or county) (State) | |
| 24. REC'D BY REGISTRAR <u>P. J. Beary M.D.</u> | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>P. B. Robinson</u> | | ADDRESS <u>Leonardtown, Md.</u> | |
| DATE <u>3/14/56</u> | | | | | | | |

3192 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

RECEIVED
MAY 18 1958
BUREAU V. S.

ATTACHMENTS

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03256

3283

CERTIFICATE OF DEATH

Reg. Dist. No.

282

| | | | | | | | |
|---|------------------------------------|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Loveville | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Loveville | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural | | | | d. STREET ADDRESS Rural | | | |
| 3. NAME OF DECEASED (Type or print) First John Middle Floyd Last Young | | | | 4. DATE OF DEATH Month March Day 19 Year 1956 | | | |
| 5. SEX male | 6. COLOR OR RACE colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11 October 1905 | | 9. AGE (In years last birthday) yrs. 50 | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor | | 10b. KIND OF BUSINESS OR INDUSTRY Md. State Road Comm. | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John H. Young | | | | 14. MOTHER'S MAIDEN NAME Rose H. Barnes | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT Stephen R.L. Young - Leonardtown, Md. | | | |
| 18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4/16x Cardiac decompensation DUE TO (b) Rheumatic cardiovascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) disease - auricular fibrillation PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 years 40 yrs? | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 1:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Neckarsville DATE SIGNED ACTUAL SIGNATURE J Roy Gopher M.D. PHYSICIAN'S NAME (Type) _____ | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/21/56 | | 22c. NAME OF CEMETERY OR CREMATORY St. Joseph Cemetery | | 22d. LOCATION (City, town, or county) (State) Morganza, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE P. Robinson | | | | ADDRESS Leonardtown, Md. | | 24a. REC'D BY REGISTRAR DATE 3/20/56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Glean D. Hannon | | | |

CERTIFICATE OF DEATH

| | | | |
|--|--|---|--|
| <p>1. Name of deceased: [Faint text]</p> | | <p>2. Sex: [Faint text]</p> | |
| <p>3. Date of birth: [Faint text]</p> | | <p>4. Place of birth: [Faint text]</p> | |
| <p>5. Date of death: [Faint text]</p> | | <p>6. Place of death: [Faint text]</p> | |
| <p>7. Cause of death: [Faint text]</p> | | <p>8. Manner of death: [Faint text]</p> | |
| <p>9. Signature of physician: [Faint text]</p> | | <p>10. Signature of registrar: [Faint text]</p> | |
| <p>11. Date of registration: [Faint text]</p> | | <p>12. Place of registration: [Faint text]</p> | |

BUREAU V. S.

MAR 31 1956

RECEIVED